EPSDT Inpatient Services

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Table of Contents

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EPSDT INPATIENT SERVICES

Early Periodic Screening Diagnosis and Treatment (EPSDT) inpatient services may be provided to treat a variety of complex health, mental health and neurological conditions that are generally prohibited as a primary reason for admission in the existing Medicaid state plan services. EPSDT inpatient services may be provided in a variety of inpatient settings based on the individual's complex healthcare needs. Individuals must be medically unstable due to medical conditions that require inpatient services to manage, treat and stabilize the medical condition and facilitate a return to a lower level of care. Some examples of conditions that may benefit from EPSDT inpatient treatment are: eating disorders, complex neurological conditions, acquired brain injury and other conditions with medical instability being the prime reason for admission.

This document will clarify the process to acquire specialized inpatient treatment benefits through the EPSDT benefit. The EPSDT benefit provides inpatient services when the individual requires intensive treatment and also requires management of multiple health conditions that cannot be effectively managed in a less intensive treatment setting.

EPSDT is a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. Examination and treatment services are provided at no cost to the individual. EPSDT is available to Medicaid/FAMIS Plus members under 21 years of age and fee for service FAMIS members under the age of 19 who meet medical necessity criteria for the service. Individuals aged 19 or 20 who are covered as part of Medicaid expansion are eligible for EPSDT.

Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to a Medicaid eligible individual through EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance may be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and

the service is determined by DMAS, its service authorization contractor or a DMAS-contracted managed care organization (MCO) to be medically necessary. Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child's needs.

DEFINITIONS

Activities of Daily Living (ADLs): Activities usually performed in the course of a normal day in an individual's life; and may include eating, dressing, bathing and personal hygiene, mobility including transfer and positioning, bowel and bladder assistance.

Anticipatory Guidance: A component of an EPSDT screening**.** It includes discussion and counseling to provide the family with information on what to expect in the child's current and next developmental phase. It emphasizes health promotion and preventive strategies. Anticipatory guidance is given in anticipation of health problems or decisions that might occur before the next periodicity visit. Anticipatory guidance topics to be considered for each visit include: health habits, prevention of illness and injury, nutrition, oral health, sexuality, social development, family relationships, parental health, community interactions, self-responsibility and school/vocational achievement. Topics may be discussed in groups or individually. Topics selected must be based on the needs of the individual child. The exact approach, topics selected, priority, and time allotted to any one topic will depend on the child's or adolescent's needs, the provider's professional judgment, and individual circumstances. The American Academy of Pediatrics (AAP) Guidelines for Health Supervision III provides guidelines on topics to cover at each periodic screening visit.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

Diagnosis and Treatment Services: Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The state may determine the medical necessity of the service and subject the service to service authorization for purposes of utilization review.

DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state

Medicaid agency that is responsible for administering the EPSDT benefit.

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment): a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, EPSDT provides examination and treatment services at no cost to the enrollee.

EPSDT Screener: DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening: EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education, including anticipatory guidance.

FAMIS: Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS enrollees are not eligible for some types of EPSDT specialized services when enrolled in a managed care organization.

FAMIS Plus: FAMIS Plus is the name given to the Virginia Medicaid program.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program that uses the DMAS provider network to deliver healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Home: A place of temporary or permanent residence, not including a hospital, ICF/ID nursing facility, or licensed residential care facility.

Inter-periodic Screenings: Screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the Primary Care Provider (PCP) may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

Medicaid: Virginia's comprehensive healthcare program that serves low income and disabled populations.

Nursing: The performance of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health and the prevention of illness or disease. Nursing includes the supervision and teaching of those who are or will be involved in nursing care along with supervision and teaching the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing. Nursing includes the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

SERVICE AUTHORIZATION (SA): THE PROCESS OF DETERMINING WHETHER OR

NOT THE SERVICE REQUEST MEETS ALL CRITERION FOR THAT SERVICE AND GIVES AUTHORITY TO PROVIDERS TO ALLOW REIMBURSEMENT FOR SERVICES. PROVIDERS AND INDIVIDUALS ARE NOTIFIED OF EACH SA DECISION WITH A SYSTEM-GENERATED NOTICE. SA FOR SPECIALIZED INPATIENT SERVICES FOR FFS ENROLLEES IS OBTAINED AT DMAS. SA FOR MANAGED CARE ENROLLEES MUST BE OBTAINED THROUGH THE MCO.

Respite: Respite is not an EPSDT service. It is defined as short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

State Plan for Medical Assistance: The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

Third Party Liability (TPL): Insurance other than Medicaid that is owned by the individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested Medicaid service. TPL must be billed for services prior to billing Medicaid.

PROVIDER PARTICIPATION REQUIREMENTS:

EPSDT Inpatient Treatment may be provided by acute care inpatient hospitals, rehabilitation hospitals, rehabilitation units of acute care hospitals and, for certain enrollees, freestanding psychiatric facilities.

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. All DMAS providers are prohibited from charging enrollees for DMAS covered services. The enrollee is not responsible for payment of medical services by ***any*** facility while under care at the enrolled provider's facility.

Freestanding Psychiatric Hospitals

Reimbursement is available for FAMIS Plus/Medicaid enrollees under the age of 21

who receive psychiatric services in a freestanding psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Inpatient Rehabilitation and General Acute Care Hospitals

FAMIS Plus/Medicaid enrollees under the age of 21 and FAMIS Fee For Service enrollees under the age of 19 may receive inpatient services approved under the EPSDT benefit in rehabilitation hospitals and in rehabilitation units of acute care hospitals.

A hospital is eligible for participation in the Virginia Medical Assistance Program if it meets one of the following criteria:

Is certified by the Virginia Department of Health (VDH) as meeting the conditions for participation under Title XVIII of Public Law 89-97

Is limited to an age group not eligible for Title XVIII benefits, but is accredited by the Joint Commission on Accreditation for Hospitals and has a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review.

ELIGIBILITY CRITERIA

EPSDT inpatient services are available to Medicaid/FAMIS Plus enrollees under 21 years of age and FAMIS fee for service enrollees under the age of 19. **EPSDT inpatient services are available only to individuals who meet medical necessity criteria for inpatient treatment**.

Children with third party insurance are eligible to receive services through EPSDT. However, the third party insurance benefits must be exhausted prior to billing DMAS.

Inpatient Services for Medicaid/FAMIS Plus and FAMIS enrollees in Managed Care Organizations

MCO Service Requests- Inpatient services are a covered service for Managed Care Organization (MCO) enrollees. Authorization for inpatient treatment services of MCO enrollees must be requested through the member's respective MCO by the individual's

physician. The Physician must contact the MCO's medical management office to initiate the authorization process for inpatient services. As mentioned above, while inpatient services are a covered service under the MCO contracts, EPSDT medical necessity criteria does not apply to FAMIS children enrolled with the MCO. In certain unique situations a FAMIS MCO enrollee may not be eligible for inpatient treatment even if the health condition and physical or mental status meets the criteria as stated in this manual.

SERVICE AUTHORIZATION CRITERIA FOR FEE FOR SERVICE ENROLLEES

Initial Requests

Accurate and complete authorization requests help reduce delays in authorization and service initiation. To ensure timely authorization for services, all requests for service authorization must be submitted to the EPSDT Service Authorization Coordinator 10-14 calendar days prior to initiation of EPSDT services or within 1 business day of the admission. A business day is defined as 12:00 am – 11:59 pm Monday – Friday with the exception of recognized holidays. Requests that are received within this time period may have the admission date as the begin date if all other requirements are met. For those initial requests that are received after this time period, the earliest begin date possible is the date the request is received.

The provider must have a Medicaid identification number for any authorized individual prior to requesting Medicaid-funded services. Providers should not start services before receiving an authorization from DMAS. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided.

Each service approval notice will indicate the last date of service coverage. The approval notification includes the start date and the end date for each approved service. Services that are not authorized are not subject to reimbursement by DMAS.

Extension Requests

If services are needed beyond the initial authorization time frame, the provider must submit an extension request. It is recommended that extension request be submitted at least 10 days prior to the end of the initial authorization period in order to avoid a break in coverage. For those extension requests that are received after the end of the previous authorization, the earliest begin date possible is the date the request is received. For

example, if a service authorization approval ends on 12/1, the provider must submit a request at least 10 days before this date in order to ensure continuation of reimbursement for services. If the request for extension is received on 12/5, the earliest date DMAS can approve the extension request will be 12/5. Therefore, the provider will not be reimbursed for services from 12/2-12/4.

Submission of Requests

Initial Service Requests must contain the following:

1. Demographics and Service Information
    1. Dates of Service being requested
    2. Medicaid Identification Number and
    3. Date of Birth
2. Intake and Clinical Assessment Summary
    1. Briefly list and describe the recommended treatment modalities for the individual
    2. Must include the reasons the individual needs interdisciplinary treatment
    3. Must include the reasons the individual's treatment cannot be managed in a lower level of care
    4. Case history including reasons for the referral and summary of recent treatment history
    5. Preliminary discharge plan and anticipated date of discharge to a lower level of care
3. Preliminary Treatment Plan
    1. List the preliminary treatment modalities prescribed for the individual
    2. List the professional disciplines that will be providing treatment and acting as clinical director for the treatment modalities within the interdisciplinary team
    3. Describe how treatment is coordinated and implemented for the individual
    4. Describe how the individual will be trained to function independently
    5. Verify that the individual can participate in the treatment milieu as defined in the treatment plan
    6. Preliminary plans for discharge to a lower level of care
4. Letter of Medical Necessity
    1. Physician or psychiatrist summaries that describe the current clinical event and generally describe the clinical need

2. Include diagnoses and relevant medical information to support treatment in an inpatient level of care

Extension Service Requests must contain the following:

1. Master Treatment Plan
    1. List the treatment modalities prescribed for the individual
2. Physician treatment summary
    1. Notes should describe how the current treatment protocol is impacting the child's clinical progress
    2. Describe the medication management and resulting medication changes

c.) Must include the reasons the individual needs interdisciplinary treatment

d.) Must include the reasons the individual's continued treatment cannot be managed in a lower level of care

3) Demographics and Service Information

1. Dates of Service being requested (dates of service must match service plan with each request)
2. Medicaid Identification Number and
3. Date of Birth
4. Dates of Service being requested (treatment plan must correspond with requested)

4) Discharge Summary

a.) Preliminary plans for discharge to a lower level of care

b.) Anticipated discharge date and disposition

c.) Summary of community based case management activity and status of all referrals completed for the individual to successfully return to a lower level of care

If DMAS requires more information in order to render a decision, the decision is pended. For all pended decisions, the requesting provider receives a request for the needed

information from DMAS. The provider must respond with the requested information within 5 working days from the request. If DMAS does not receive enough information to make a clinical decision the request will be rejected or in some instances the request will be denied.

Denials of Service

If the service request is denied, a letter will be sent to the provider and individual/family indicating the reason for the denial. This letter will include appeal rights. Each service denial is reviewed and denied by a physician using EPSDT "correct or ameliorate" medical necessity criteria.

DMAS will provide a ten day notice before service reimbursement is ended. DMAS provides the 10 day advance notice of adverse actions by issuing a service authorization notification including the covered dates of service for each service approval. For individuals who have existing/active service authorizations and who request an extension of those services, the end date as listed on the existing/active service authorization will provide the advance notice for potential service denials if the extension request is not approved by DMAS. It is very important that providers request service authorizations in a timely manner so that reimbursement is not lost for those patients who are residing in your facility at the time when future services are denied. Active discharge planning should be an ongoing activity when individuals may not meet the medical necessity requirements for continued inpatient care.

COVERED SERVICES AND LIMITATIONS

Covered Services

EPSDT Inpatient Services consist of interdisciplinary treatment, service coordination, discharge planning and case management, nursing, behavioral support counselors, and equipment necessary to implement the treatment program

Out of State Placements

DMAS may negotiate individual contracts with in-state or out-of-state facilities for individuals who present with unique or intensive treatment needs that cannot be served within the existing DMAS provider network. Treatment options explored in-state must be documented and the reason the option was denied or would not meet the individual's treatment needs must be included. This information must be submitted to DMAS for out of

state placements to be considered.

Behavioral Support Services

The support provided by a one to one behavioral support staff may be reimbursed when authorized as part of the treatment plan and when determined to be medically necessary for the individual to participate in and benefit from the approved treatment program.

Leave of Absence

The day on which the individual begins a leave of absence or furlough is treated as a day of discharge and is not considered a day of inpatient care. The day the individual returns from a leave of absence or furlough is treated as a day of admission and is considered a day of inpatient care if the patient returns to the hospital by midnight.

It should be noted that leaves of absence are permitted for therapeutic purposes only. The objectives of the leave of absence must be documented prior to the leave, and the goals obtained and an evaluation of the leave must be documented upon the patient's return. Leaves of absence for procedures which are not available at the treating facility (for example, CAT scan, or renal dialysis) are considered medical therapeutic leaves.

Non-Covered Services

Reimbursement for services when the individual no longer meets medical necessity criteria is not covered. Special services which are not authorized by DMAS or the MCO are not covered.

Included Per Diem Services:

The following services are included as part of the per diem reimbursement.

- Interdisciplinary treatment programming
- Nursing
- Behavioral support staff using the established staff to patient ratio
- Equipment necessary to implement the treatment program
- Clinical Supervision related to the treatment plan
- Case Management/Discharge Planning
- Treatment Team Activity
- Pharmacy

Not Included in Per Diem:

The following services are not included as part of the per diem reimbursement. All services included in this list may be reimbursed separately through the Virginia Medical Assistance Program when provided by a DMAS enrolled provider. If the facility meets DMAS enrollment criteria to provide some or all of the excluded services, then they may enroll with DMAS as a provider of that service type. Service limits may apply and authorization for certain services is required.

- Any general medical needs not addressed in the inclusive per diem services listed
- Durable medical equipment or non-routine medical supplies
- Professional services and diagnostic testing outside of the treatment facility

*The facility agrees to use providers of services that are enrolled in the Virginia Medicaid program for all services not provided by the facility. The enrollee is not responsible for payment of medical services by ***any*** facility while under care at your facility.

FREESTANDING (PSYCHIATRIC) HOSPITAL UNDER AGE 21

EPSDT Inpatient reimbursement is available for FAMIS Plus/Medicaid enrollees under the age of 21 in a freestanding psychiatric hospital and other settings as appropriate to treat the primary health condition of the individual. The need for these services must have been identified through an EPSDT screening. When services are requested in a freestanding psychiatric hospital, the request must contain an independent team certification in the enrollee's locality.

The criteria for Medicaid reimbursement for inpatient psychiatric services is based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

Independent Team Certification

Federal regulations (42 CFR § 441.152) require certification by an independent team that inpatient psychiatric services are needed for any member applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals, including a physician. The independent team will be from the Community Services Board (CSB) serving the area in which the individual resides. Pre-screenings are not reimbursable by Medicaid. For Comprehensive Services Act (CSA) children, the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council. The majority of the team (at least 3 members) and the physician must sign the Certificate of Need/DMAS 370 form (see the "Exhibits" section at the end of this chapter for a sample of this form). Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual's situation (42 CFR § 441.153). The justification for certification must be child-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

A Medicaid-reimbursed admission to an acute care facility or a freestanding psychiatric facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the member;

2. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.

The certification of need for hospital admission and for non-CSA residential placements must be documented on the Pre-Admission Screening Report (DMH 224) or similar form, which must be signed and dated by the screener and the physician For non-CSA residential placements the DMAS 370 may also be used. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

If a child resided in a psychiatric residential facility, requires an acute psychiatric admission, and is returning to a psychiatric residential facility, a new Certificate of Need is required. The certification may be completed by the acute facility physician and treatment team as long as the physician meets the criteria noted in federal regulations 42 CFR 441.152-153.

A physician, physician assistant, or nurse practitioner acting within the scope of practice and under the supervision of a physician must recertify for each member that inpatient psychiatric services are needed. This must be done at least every 60 days.

MEDICAL NECESSITY CRITERIA

1. The individual must require all of the following services:

    - Physician assessment and clinical direction
    - Psychiatric or Neuropsychiatric assessment and clinical direction
    - Psychotherapy including family psychotherapy
    - Behavioral Modification including training in adaptive functioning (must include family and caregiver training once discharge dates are established)
    - Active Medication Management

2. The individual must also require two (2) or more of the following services based on their clinical needs

    - Psychiatric Nursing or Rehabilitative Nursing
    - Physical Therapy
    - Occupational Therapy
    - Speech/Language Pathology Services;
    - Nutritional Services

3. Treatment Plan goals should address how the individual will increase adaptive and

functional behaviors based on the individual's cognitive abilities.

4. Treatment Plan goals should be realistic and possible to achieve within the approved period of admission.

5. Individual must require coordinated interdisciplinary treatment based on the complexity and intensity of the person's medical conditions.

6. An intensive coordinated interdisciplinary team approach is not available at a lower level of care.

7. The individual is able to actively participate and benefit from the treatment regimen as listed in the service plan

8. The Treatment Plan must describe how the individual's ability to function as independently as possible will be addressed.

9. Description of the discharge plan and goals towards reaching the intended plan.

10. Documentation that supports all of the above requirements must be submitted with the service authorization request.

Continuing Stay Criteria:

If the initial authorized treatment time period is not sufficient to achieve the individual's goals and discharge is not possible, the provider must request additional days of treatment. Below is non-inclusive list of items that must be submitted to DMAS for consideration of an extended authorization.

1. A clear medical justification of why all admission goals were not achieved within the initial period of authorization.

2. Documentation that demonstrates significant improvement of the patient's medical conditions and the justification for continued stay must demonstrate how treatment is expected to increase adaptive and functional behaviors.
3. Increased functioning must be demonstrated by baseline comparisons as developed during the initial treatment period.

4. Individual must continue to require coordinated interdisciplinary treatment based on the complexity and intensity of the person's medical conditions.

5. Demonstration that an intensive coordinated interdisciplinary team approach is still not available/appropriate at a lower level of care.

6. The individual continues to be able to actively participate and benefit from the treatment regimen as listed in the service plan.

7. The treatment plan must describe how the individual's ability to function as independently as possible will continue to be addressed.

8. Documentation that supports all of the above requirements must be submitted with the service authorization request for an extension.
9. Description of progress towards intended discharge plan.

Discharge Criteria:

EPSDT Inpatient services do not meet reimbursement criteria when the individual's clinical care needs meet one of the criteria listed below:

1. All treatment goals are met,
2. The individual does not require coordinated treatment from multiple disciplines
3. The individual would successfully benefit from a lower level of care
4. The individual does not benefit from treatment or
5. The individual refuses to participate.

INDIVIDUAL'S RIGHT TO APPEAL AND FAIR HEARING

The Code of Federal Regulations at 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the individual. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, services may continue during the

appeal process. However, if the agency's action is upheld by the hearing officer, the individual will be expected to repay DMAS for all services received during the appeal period. For this reason, the individual may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The individual or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street, 11th floor

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. Documents received after 5:00 p.m. on the deadline date shall be untimely.

PROVIDER APPEALS OF ADVERSE ACTIONS

State Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action, which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director’s decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of denial to the Maternal and Child Health Division at the following address: NEEDS UPDATING

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, the provider may appeal the reconsideration decision.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 11th Floor

Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 11th Floor

Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 am through 5:00 pm. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the member (client) for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

DOCUMENTATION REQUIREMENTS

For each individual, there must be a written plan of care/treatment plan established and periodically reviewed and signed and dated by a physician. Services not specifically documented in the individual's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS or its contractors. Each entry in the medical record must be signed and dated (month/day/year) by the provider of treatment.

The medical record must include all of the following, but is not limited to:

- Diagnosis, current medical findings, including functional status, and the clinical signs and symptoms of the individual's condition, including the diagnosis justifying admission, and documentation of the extent to which the individual is aware of the diagnosis and prognosis;
- An accurate and complete chronological picture of the individual's clinical course and treatments, including any prior rehabilitation/inpatient treatment. If appropriate, the summary of treatment furnished and the results achieved during previous periods of rehabilitation services or institutionalization must be provided;
- Plans of care/treatment plans by the interdisciplinary team and each involved discipline, specifically designed for the individual to include realistic, individualized, measurable, individual-oriented goals with time frames for achievement;
- Physician orders and plan of care/treatment plan prior to the provision of services;
- Documentation of all treatment rendered to the individual with specific attention to the frequency, duration, interventions, response, and progress toward established goals. All entries must be fully signed and fully dated (include month, day and year) by the provider of the treatment (include the full name and title);
- Documentation of supervision of therapy assistants completed by a licensed therapist every 30 days;
- Documentation of changes in the individual's condition and changes in the plans of care/treatment plans (team and/or individual discipline);
- Documentation treatment team conferences and consultations, including the names of all attending;

- Discharge plans (see below); and
- Discharge summaries describing functional outcome, follow-up plans, and discharge disposition. The discharge summaries must be completed within 30 days of the individual's discharge.

Discharge Planning

Discharge planning must be an integral part of the overall plan of care/treatment plan developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The individual and/or the responsible party shall participate in the discharge planning. The discharge plan must demonstrate that adequate arrangements/services are made to meet the individual's needs in the new environment. Documentation concerning changes in the discharge plan as determined by the response to treatment, shall be entered into the record at least every two weeks as a part of the team conference, but more often if the individual's situation warrants.

Interdisciplinary Team

The interdisciplinary (ID) team must prepare written documentation of the ID plan of care/treatment plan within seven (7) calendar days of admission.

Documentation must include, but is not limited to:

- Needs of the individual;
- Individualized, measurable individual oriented long and short-term goals;
- Approaches/interventions to be used to meet the goals;
- Baseline data on goal performance
- The discipline(s) responsible for the interdisciplinary goals;
- Evidence of goal revision and progress;
- Time frames for all goals ; and–
- Team plan reviewed/revised at least every two (2) weeks

Included in the interdisciplinary plan of care/treatment plan must be a discharge plan. This plan must facilitate an appropriate discharge and must include, but is not limited to:

- Anticipated improvements in functional levels;

- Time frames necessary to meet the goals;
- Individual's discharge destination;
- Any modifications and alterations necessary at the individual's home for discharge; and
- Alternative discharge plans if the initial plan is not feasible.

Since the effectiveness of an interdisciplinary treatment program depends on the continuing coordination of all the disciplines involved in the individual's treatment, team conferences must be held at least every two weeks in order to review the plan of care/treatment plan, assess and document the individual's progress as well as any problems impeding progress. The team will consider possible resolutions to the identified problems, reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation, reassess the need for any adjustment in these goals or in the prescribed treatment program, and re-evaluate discharge plans. Documentation must demonstrate a coordinated team approach. A review by the various team members of each others' progress notes does not constitute a team conference. A summary of the conference, noting the team members present, must be recorded in the clinical record at least every two weeks. Team conferences (identifying those persons attending the meeting), must be held at least every two weeks to review the plan of care/treatment plan. Documentation must include approaches and progress made toward meeting established interdisciplinary goals, revisions/changes to goals, and the discharge plan.

CLAIMS AND BILLING

For detailed reimbursement instructions please refer to the billing instructions located in Chapter 5 of the DMAS Hospitals Manual.

All services require authorization by DMAS. The revenue code used is an all inclusive revenue code to be reimbursed on a "per diem" basis.

UB-04 Billing Codes used for EPSDT inpatient services:

0770 Preventive Treatments

On the CMS-1450 (UB-04) form:

- Locator 63: Treatment Authorization Code – Enter the 11-digit preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.

Send claims for approved enrollees to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Maintain the providers copy in your files for future reference.